Revised 7/14/2010 **Participant #___**

Better Choices, Better Health: Living Well Alaska
Workshop Participant Pre-Form

Please fill out this form, **both pages**, **BEFORE** you complete the Workshop.
Please put your participant # (from Attendance Record) on this form.

1. Where is this Workshop being held? (e.g., Knik Senior Center, 1 Main St, Knik AK 99712)

Site/Location: _____

Address: _____ City: _____ Zip: _____

2. When is this Workshop being held?
Class dates (mm/dd/yyyy): **from** ____/____/_____ **through** ____/____/_____

3. Have you ever been told by a doctor that you have? *(Please circle ALL that apply):*
   - **a) Arthritis**
   - **b) Anxiety or Depression**
   - **c) High Blood Pressure**
   - **d) Cancer**
   - **e) Diabetes**
   - **f) Stroke**
   - **g) Lung Disease (asthma, bronchitis, emphysema)**
   - **h) Heart Disease**
   - **i) Osteoporosis**
   - **j) Another condition (please specify): _____**
   - **k) None**

4. Why are you taking this Workshop? *(Please circle ALL that apply):*
   - **a) I want to learn to take care of myself better.**
   - **b) I live with or care for someone with a chronic disease.**
   - **c) My health care provider recommended it.**
   - **d) I was referred by _____**
   - **e) Another reason:_____**

5. Are you *(please circle one)*: **Female Male** 6. How old are you? _____ *Age in years*

7. What is your home zip code?_____ 8. How many persons live in your home? _____

9. Race/Ethnicity: Please check all that apply.

__ White/Caucasian **__ Asian** **__ Other: _____**
__ Black/African American **__ Pacific Islander**
__ Alaska Native/American Indian **__ Hispanic/Latino**

10. Education: Please check the highest level of education you have completed.

__ Less than high school **__ Some college or vocational school**
__ Some high school **__ College graduate**
__ High school graduate **__ Graduate school**

11. What type of health insurance do you have? (*Please check all that apply*)

__ None **__ Private Insurance** **__ I.H.S.**
__ Medicare **__ V.A. Benefits Insurance**
__ Medicaid **__ Other (specify): _____**

Complete both pages

11. In general, would you say your health is…… (*Circle one*)

Excellent.....1
Very good.....2
Good.....3
Fair.....4
Poor.....5

12. On a scale of 1 to 10, how confident are you that ***you*** can live a healthy life with your chronic condition? *Circle answer.*

not at all confident	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**totally confident**

13. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as cooking, bathing, household chores, physical activity, self-care, work, or play?

_____ **Number of days**